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FISCAL IMPACT STATEMENT

LS 6527
BILL NUMBER: HB 1328

NOTE PREPARED: May 3, 2013
BILL AMENDED: Apr 27, 2013

SUBJECT: Health Matters

FIRST AUTHOR: Rep. Brown T
FIRST SPONSOR: Sen. Patricia Miller

BILL STATUS: Enrolled

FUNDS AFFECTED: X GENERAL
DEDICATED
X FEDERAL

IMPACT: State

Summary of Legislation: This bill has the following provisions:

(1) Defines populations that may be subject to Medicaid resource requirements.
(2) Eliminates certain Medicaid eligibility resource requirements.
(3) Specifies Medicaid recipients who are eligible to receive payments related to certain Medicare premium and cost-sharing amounts.
(4) Sets forth requirements for continuing care retirement communities that were registered before January 2, 2007.
(5) Provides for implementation of the federal Patient Protection and Affordable Care Act (ACA) with respect to a Health Insurance Exchange (HIX) in Indiana.
(6) Specifies that Indiana insurance law applies to a health plan offered through a HIX to the same extent that the law would apply if the health plan were offered independent of the HIX.
(7) Specifies requirements for health plans issued through a HIX.
(8) Requires a navigator to be certified and an application organization to be registered before providing services with respect to a HIX.
(9) Provides for dissolution of the Indiana Comprehensive Health Insurance Association (ICHIA).
(10) Requires the Office of Medicaid Policy and Planning (OMPP) to report to the Health Finance Commission specified information regarding the participation of the aged, blind, and disabled Medicaid population in risk-based managed care, managed fee-for-service programs, and home and community-based services management programs.
(11) Requires the Office of the Secretary of Family and Social Services Administration (FSSA) to report specified information to the Legislative Council and the Health Finance Commission concerning school health

care clinics in Indiana.

Effective Date: Upon Passage; July 1, 2013.

Summary of NET State Impact: The bill provides enabling language to allow the Department of Insurance (DOI) and the FSSA to adopt rules and to contract with and share data with a health insurance exchange. These provisions are required as a result of the implementation of the ACA. The establishment of regulations concerning navigators and assisters is intended to be self-funding.

The dissolution of ICHIA would result in savings of approximately $10.6 M in FY 2014 and $48.85 M in FY 2015 if the current appropriation level is considered to be the baseline budget. The bill also provides that any funds remaining in ICHIA on the date of the final dissolution must be transferred to the General Fund.
The conversion of the state Medicaid aged, blind, and disabled eligibility status from the use of state disability standards to Social Security Program standards (1634) is estimated to result in savings of approximately $23 M. The elimination of resource/asset standards for certain categories of Medicaid eligibility is required by provisions of the ACA.

Explanation of State Expenditures: *Summary*: The bill specifies the DOI shall provide oversight of insurance products offered through the HIX, including registration and certification requirements for HIX navigators and application organizations. The provisions of the bill affecting the DOI are expected to increase the agency's workload and/or operational expenditures. However, the bill requires the DOI to collect fees from navigators and application organizations, which, as required by the bill, are to be sufficient to cover any increased costs for providing the necessary regulation and oversight.

The bill also dissolves ICHIA and eliminates the 6-month waiting period for Healthy Indiana Plan (HIP) participation of individuals who formerly participated in ICHIA. The repeal of ICHIA could result in state savings of approximately $10.6 M in FY 2014 and $48.85 M in FY 2015. Eliminating the 6-month waiting period of the HIP program for displaced ICHIA participants will require a Medicaid waiver to be submitted to the Centers for Medicare and Medicaid Services (CMS) and approved in order to receive the federal matching funds for this population, which is likely to be small.

The bill provides enabling language to allow DOI and FSSA to adopt rules, to contract with, and to share data with a HIX. These provisions are required as a result of the implementation of the ACA.

Medicaid Resource Standard Revision: The bill provides that, excluding the aged, blind, and disabled population, most Medicaid eligibility categories applicable to applicants between ages 19 and 65 will have no resource test applied to determine Medicaid eligibility, as required under the ACA. The fiscal impact of this provision, if any, should be a factor in the "woodwork effect" projections included in the September 18, 2012, "Milliman Medicaid Financial Impact Analysis" and should therefore be included in the April Medicaid forecast.

Elimination of the Section 209(b) Status/Conversion to 1634 Status: The bill specifies that the aged, blind, and disabled population will be subject to asset limitations established by the federal Supplemental Security Income program and to an income limitation of 100% for the federal poverty level (FPL). The bill also specifies Medicaid recipients who are eligible to receive payments related to certain Medicare premium and

cost-sharing amounts. These provisions are linked to the conversion of the state to 1634 disability determination status. The net fiscal impact of the provisions is estimated to be $23 M in state savings.

Additionally, the bill will increase the workload of FSSA (1) to report information concerning school health care clinics to the Health Finance Commission and Legislative Council and (2) to provide certain information on risk-based managed care, managed fee-for-service programs, and home and community-based services to the Health Finance Commission. Increases in FSSA workload are expected to be accomplished within existing funding levels.

Additional Information:

Revision of the Medicaid Resource Standard: In accordance with the ACA, the bill eliminates provisions allowing resource standards for pregnant women, children, and other specified populations. The bill specifies that resource standards may be applied to recipients and applicants that are aged, blind, or disabled, SSI-eligible, a person meeting level-of-care requirements and applying for long-term care services, or an individual applying for Medicare cost-sharing assistance. Most other eligibility categories between ages 19 and 65 will have no resource test applied. This provision of the ACA is intended to streamline the Medicaid application and eligibility determination process and is based on the assumption that the majority of low-income persons who earn less than the income eligibility standards do not have assets that would enable them to pay for health care. The fiscal impact of this provision, if any, should be included in the September 18, 2012, "Milliman Medicaid Financial Impact Analysis" as part of the "woodwork effect" and should therefore also be included in the April Medicaid forecast.

Elimination of the Section 209(b) Status and Conversion to 1634 Status: The bill specifies that the aged, blind, and disabled population will be subject to asset limitations established by the federal Supplemental Security Income program. This provision would allow for the elimination of the separate disability determination process and the associated expenses, as well as the spend-down program. The bill specifies that the qualifying income level for the aged, blind, and disabled population is to be 100% of the FPL.

Medicare Savings Program: The bill also specifies low-income Medicaid recipients who are eligible to receive payments related to certain Medicare premium and cost-sharing amounts. These provisions are linked to the conversion of the state to 1634 disability determination status. The net fiscal impact of conversion to 1634 status is estimated to be $23 M in state savings.

Oversight of Insurance offered on the HIX: The bill specifies the Department of Insurance would provide oversight of insurance products provided through the HIX. The ACA specifies that all insurance offered on the HIX must meet state insurance requirements as well as federal provisions. The bill also allows the DOI to enter into contracts with a HIX for the performance of necessary functions and to share information necessary to implement the HIX. The workload of the DOI will increase with the implementation of the federally facilitated exchange as a requirement of the ACA.

Registration and Certification of Navigators and Application Organizations: The bill also requires that individuals or application organizations intending to act as navigators in Indiana under the ACA must meet state certification and registration requirements for HIX navigators or application organizations. (Federal rules implementing the HIX specify that in order to receive a navigator grant, individuals or entities must meet any licensing, certification, or other standard prescribed by the state or the HIX, if applicable.)

The DOI, in consultation with FSSA, is required to develop (1) a curriculum for a required course of study and an examination that will be requirements for the certification of navigators and (2) policies and procedures to allow a registered application organization to develop a training program to train navigators who perform services on behalf of the organization. The bill also requires development of continuing education requirements for ongoing certification and for a process for an insurance producer or consultant to qualify to be designated as a navigator.

The development of the certification and registration program will impact the workload of the DOI; however, the DOI is required to collect fees sufficient to cover the implementation of the certification and registration program. The DOI will need to promulgate rules to establish the requirements of the navigator or application organization certification and registration requirements. Rule-making is considered to be a core activity of agencies and should be able to be accomplished within the current level of resources available.

Dissolution of ICHIA: As a result of the ACA and its elimination of preexisting conditions exclusions, limitation of annual and lifetime caps, and the inability to reject applicants due to health conditions, the ICHIA program is no longer necessary. There will no longer be a need to operate the high-risk ICHIA program after coverage for insurance sold on the HIX becomes effective January 1, 2014. The bill requires the corporation to submit a plan of dissolution and specifies items that must be included in the plan. The DOI is responsible for approval of the dissolution plan. The termination of the ICHIA program is not a requirement of the ACA - it is no longer necessary because of the ACA.

The dissolution of ICHIA will require ICHIA participants to transition to qualified insurance products sold on the HIX. (These products are projected to cost less than the coverage offered under ICHIA.) The ICHIA General Fund appropriation for the current biennium is $97.7 M. The corporation has prepared a plan for termination and transition of participants, which is included in the FY 2014-FY2015 budget request. The ICHIA has requested $38.25 M for the upcoming biennial budget to pay the remaining projected incurred claims tail and to discontinue other activities managed by the program. If the current appropriation level is considered to be the baseline budget, the dissolution would result in savings of approximately $10.6 M in FY 2014 and $48.85 M in FY 2015. The bill also provides that any funds remaining in ICHIA on the date of the final dissolution must be transferred to the General Fund.

Effect of Termination of ICHIA Coverage on Healthy Indiana Plan (HIP): The bill would allow former ICHIA participants who no longer have coverage under ICHIA to be eligible for HIP until December 31, 2013. This provision would allow ICHIA participants meeting the income eligibility and other requirements of the HIP Medicaid waiver to receive coverage. The provision would require a waiver amendment to be submitted to CMS and approved in order to receive the federal matching funds for this population, which is likely to be small.

Explanation of State Revenues: The DOI is required to collect from navigator or application organization applicants for certification, registration, and renewal fees sufficient to cover the costs of implementing a prescribed course of study, an examination, and continuing education requirements. [See *Explanation of State Expenditures* above.]

Continuing Care Retirement Communities (CCRCs): The bill specifies that CCRCs that met the original definition of CCRC continue to be defined as a CCRC as long as a single contract continues to be in force. (CCRCs are exempt from the collection of the Health Facility Quality Assessment Fee (QAF).) This provision continues the status of the existing CCRCs and should therefore have no impact on the QAF.

Explanation of Local Expenditures:

Explanation of Local Revenues:

State Agencies Affected: DOI; ICHIA; FSSA.

Local Agencies Affected:

Information Sources: Douglas Stratton, ICHIA Executive Director; Logan Harrison, DOI; Seema Verma, Indiana State Health Care Reform Lead, FSSA; "General Guidance on Federally-Facilitated Exchanges", Center for Consumer Information and Insurance Oversight, CMS; Federal Register/Vol. 77, No. 59, March 27, 2012, Section 155.210 and Section 155.220.

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